Exhibit D

Supplemental Report of the BDO Center

for Healthcare Excellence and Innovation

The BDO Center for Healthcare Excellence and Innovation issued its original Report on July 27, 2021 evaluating the proposed Settlement Allocation Methodology. We have subsequently been asked to review the following documents and provide additional expert opinion in response to:

1. Subscriber Plaintiffs' Memorandum of Law in Support of Motion For Final Approval of Class Settlement
2. Expert Declaration of Dr. Joseph R. Mason, Dated September 3, 2021 ("Mason Declaration")

Summary

The Mason Declaration expresses support for the current proposed settlement allocation as "economically reasonable" based on three factors: first, the relative differences between the market for Administrative Services Only (ASO) arrangements purchased by Self-Funded (SF) plans and the market for Fully Insured (FI) plans; second, the differences in time periods for FI and SF members; and, third, the relative circumstances of the SF and FI classes related to the Settlement. These foundational statements made with no authority, no science, and no supporting detail reflect the sweeping generalities found throughout Prof. Mason's Declaration. It is clear that Prof. Mason has once again failed to consider key characteristics of the health insurance industry and has failed to consider how Blue Cross Blue Shield ("BCBS") itself compares SF and FI plans to one another.

Prof. Mason contends that his proposed allocation methodology is correct *"after"* (1) Adjusting for economic differences between FI and ASO plans, and (2) Accounting for differences in the legal risks faced by the 2 classes. With regard to the former, we address that later in our response; with regard to the latter, in this context it feels like Prof. Mason is reaching and opening streams of argument for arguments sake with little relevancy to the method of allocation of Settlement Damages.

Moreover, Prof. Mason creates an argument that there are two separate markets, one for FI Customers and one for SF Customers, each with different competitor sets and market power. This is not the reality of how business is transacted in the US healthcare marketplace, as detailed below.

The BCBS organization is built like most commercial payors in US healthcare: One central organization supporting different product lines. The central organization provides the operating platform for things like product development, eligibility processing, claims processing, medical management, network management. These are the core "value drivers" for the products; in this case, health plans: HMOs, PPOs, EPOs. The underlying funding mechanism for these products (Fully Insured and Self Insured Plans) is secondary to the product itself which they are purchasing.

Specifically, they are purchasing health insurance benefits products which are delivered via:

- A contracted network of healthcare providers, via agreements whose terms are materially the same for FI and SF patients/clients; and

- Health plan operations, Stop Loss Insurance, Pharmacy Benefit Services and other administrative support services (care management, network management, product development) which are materially the same whether the patient/client is from a FI plan or a SF plan.
- Payors leverage these assets, especially their network discounts, to provide equal/near equal value to FI and SF customers.

The other core value driver is Brand. And this is especially true as it relates to the Blues plans. In the case of the Blues plans, Brand is the strongest in the industry among its competitors. In our experience, Brand is worth 2.0-2.5% premium equivalent in the Blues plans. The Blues enjoy the rare status of Metonymy in Brand Awareness. Through usage a trademarked name or brand becomes a generic term — a common noun or verb used in daily conversation and writing. A generic trademark is considered a form of metonymy — a figure of speech that uses a word or phrase as a substitute for something for which it is closely related (e.g., the White House for U.S. Government or Wall Street for big business). (Cite: Ankins Bookshelf). A national Head of Sales for a large competing health insurer shared an anecdote about how at an Open Enrollment meeting a worker commented that "I get my Blue Cross through AETNA". The Blue Cross brand is equated to medical coverage, and in many consumers' minds, there isn't a difference between the provider of healthcare (i.e., the doctor) and the health insurer (i.e., Blue Cross)

Background of Health Insurance Plans

Prof. Mason's attempt to define FI and SF in section VI is flawed in many ways but the biggest flaw is oversimplifying the "claims cost uncertainty" aspect of his argument. The reality is that both types of the BCBS plans provide materially the same claims cost uncertainty via the network discounts and stop loss coverage. BCBS's products offer both administrative services and claims cost uncertainty to materially the same level of value for SF and FI clients.

Consistent with the equal uncertainty to both SF and FI clients, in the Subscriber Plaintiffs' Memorandum of Law in Support of Motion for Final Approval of Class Settlement and Appointment of Settlement Administrator filed on September 3, 2021 at page 53, the Subscriber Plaintiffs admit that FI and SF plans were not only subject to the same anti-competitive conduct, but in fact that SF plans were subjected to additional conduct that FI plans were not.[1]

Another core misrepresentation carried throughout the argument is the "relative profitability" of SF and FI clients. Profitability on FI v ASO is not as relevant a driver in allocation methodology as Prof. Mason attempts to argue. This is another "apples-to-oranges" comparison. It does not

[1] "The statement reads: Moreover, as a result of the nationwide reach of the alleged conspiracy, Subscriber Plaintiffs allege that virtually every member of the Damages Class suffered antitrust injury through higher premiums, depressed competition, lessened innovation, and loss of consumer choice . . . Within the Self-Funded Sub-Class, predominance is also satisfied; *in addition to the above*, members of the Self-Funded Sub-Class *also* faced common questions concerning the impact of the alleged conduct on administrative fees and the market for national accounts." (Emphasis added.)

really adequately reflect the effect and implications of BCBS' anti-competitive behavior across the two classes but rather quantifies it as such for their own benefit in allocation methodology.

Prof. Mason consistently minimizes the value of SF clients, and further, TPA/ASO business; yet the facts of the matter support that in fact SF/ASO/TPA clients/business was and is of increasing importance to BCBS plans, given the national employer purchasing trends and increased intense competition from United Healthcare plans nationally. Additionally, in 2010 one of the largest Blues plans launched a "TPA Strategy" to address these very issues. The strategy summarized that while the transactional TPA administrative services are low profit, the "value-added" services of Health Management, Pharmacy and Stop loss/Reinsurance are where "margins will be made". This is consistent with margin build/profit load works in the insurance industry and why all insurers, including BCBS, increasingly are moving their business model to maximize that value.

It is important to note that Prof. Mason and Subscriber's counsel both reference this same 2010 report but completely misinterpreted the report's meaning and claims that the report stands for the proposition that ASO's are loss leaders when in fact the report stands for just the opposite – that ASO agreements include "value-added" services which create margins for BCBS and are very profitable. We outlined the importance to BCBS of these "value-added" services to the ASO revenues in our initial BDO Report. Prof. Mason and the Subscriber Plaintiffs are wrong about the SF plans being "loss headers".

On this point, sworn testimony from BCBS executives and the BCBS documents prove BDO's analysis to be correct and Prof. Mason and Subscriber Plaintiffs being wrong. In an antitrust

injunctive action brought by the Department of Justice in the United States District Court for the District of Columbia, Stephen Schlegel, Vice President of Corporate Development for Anthem, the largest of the Blues, testified about how to compare what ASO customers pay and what fully-insured customers pay and emphasized that claim costs must be addressed to get a fair comparison: "to put an ASO account on the same basis as a fully-insured account, what we do is we take the ASO fee that we collect from the client, plus the claims that we pay on their behalf, and add that together to approximate what a fully-insured premium might be. That way an ASO account is on the same basis as a fully insured account." (Exhibit A at 1407:1–7) (emphasis added). Anthem's VP described this as calculating a "premium equivalent" for self-funded plans, *id.,* the same approach BDO has declared is appropriate here in its original Report. Anthem has thus testified under oath that this is the proper method for comparing self-funded and fully-insured blocks of business, yet that method was inexplicably not used by Prof. Mason in apportioning the settlement. Prof. Mason's failure to use BCBS' own methodology is inappropriate.

While the failure to account for claims is the largest quantitative problem with the settlement apportionment, it is not the only problem. The apportionment also ignores the numerous other cost and revenue items by which the Blues profit at the expense of the Self-Funded Class. Such items are discussed in BDO's previous Report and at pages 24–28 of the Self-Funded Objectors' Objection, and include items like stop-loss premiums, pharmacy spreads, retention of pharmacy rebates, and utilization management fees, among many others. Sworn testimony from another Anthem witness in the successful DOJ proceeding to enjoin the Anthem-Cigna merger confirms that "you have to add in all the profitability, every one of those other lines of business associated

with that national home and national home ASO, to do a true comparison…." (Exhibit B at 1725:11–14).

The "loss leader" contention made by Subscriber Plaintiffs and Prof. Mason is a red herring. It is contradicted by the very BCBS documents upon which Subscriber Plaintiffs and Prof. Mason try to rely. The ASO fees as a "loss leader" is, if anything, to persuade SF plans to use BCBS as a TPA, then BCBS makes its margins - profits – on the very same value – added services that BDO previously described. This also proves another point made in BDO's initial Declaration – BCBS makes significant profits from its SF business.

Employers on average see savings of approximately 20-35% when going from fully Insured to self-insured funding. Every savings scenario differs based on the particular employer and year of claims experience. Some scenarios could see little to no saving, while some scenarios could see as high as 40% savings. Per our analysis, the components of the 20-35% savings range are as follows: 2-4% for claim trend; 4-6% for claims fluctuation & morbidity margin; 3-5% for mandated benefits; 3-5% for administrative expenses; 4-6% for taxes & fees; 3-5% for profit & risk loading.

On the issue of Substitutability, we agree with Prof. Mason that FI and SF plans are essentially substitutes and each constrain the price of the other – because an employer performs the financial analysis of its OWN situation and chooses the better approach to suit its needs. See Mason Declaration, paragraphs 23, 27 and 28. The fact that there has been a continuous shift in employers from the fully insured to the self-funded mechanism indicates that on average, savings exist in doing so. As detailed in our analysis, these savings range from 20-35%.

Assessment of Settlement Allocation

Prof. Mason's various ratios as proxies for the overcharges mentioned in paragraph 31 present an overly simplistic and myopic view of healthcare and how health insurance works. It is the Blue Cross entire membership portfolio (fully insured, self-funded, government, etc.) that enables them their leverage in negotiations with their partners (providers, etc.) – which in turn affect medical claim amounts and other programs that ultimately impact healthcare spend - and this equally impacts both the fully insured and self-funded market. He puts a good deal of effort in creating numerical exhibits that compare the SF ASO fee to the FI premium rate. That is a flawed methodology because they are not on the same basis as Prof. Mason ignores SF paid claim costs and ignores the value – added services that BCBS admits is where it makes its margins on SF plans – the ASO fee represents only a portion of the premium equivalent spend for SF employers, while the FI rate premium rate represents the 100% of the healthcare spend – including the medical claims BCBS are required to pay to outside providers. Prof. Mason's failure to include the SF value – added services and the paid claim costs in the ASO revenues renders his analysis meaningless. Prof. Mason cannot leave out margins from services that BCBS considers in its comparison of SF and FI plans and present a proper allocation model.

Prof. Mason's application of a discount factor is also inexplicable and unsupportable. Actuaries have deep expertise in the application of discount rates regarding time value of money, and I have never seen a methodology that remotely resembles Prof. Mason's application of it. A critical component of time value of money calculation translates the value of future investments into

today's dollars (present value) or today's dollars into future amounts (future value). Plainly said, a dollar today is worth more than a dollar tomorrow.

Prof. Mason takes a 9% discount rate (3% treasury + 6% risk premium) and discounts it for 8 years to arrive at a 50% discount factor – which he uses to discount the SF allocation he derives applying his overcharge methodology. So, he essentially compounds a flawed methodology with an even more flawed concept. A discount rate should be applied to streams of cash to determine what those same amounts would be at certain points in time. A discount rate should never be used under a merit-based premise in determining who is entitled to what amount. We were, therefore, not surprised that Prof. Mason cited to **no authority** for the use of a discount factor in this type of situation.

Prof. Mason proceeds to summarize his perspectives on "financial comparisons" of the FI, SF markets, centered around Gross Revenue, Operating Gain, and a difficult to follow comparison of "Changes in Revenue Associated with Administrative Services and Risk Transfer Per Member Revenue".

We've argued that Revenues are comparable between FI Premium and SF Premium Equivalents, and the data supports that. In fact, the BCBS "Best Efforts Rules" define Premium Equivalents as a measure of compliance with the BCBS Licensee agreement. To put an ASO client on the same comparative analytical basis as an FI client, the methodology is to take the ASO Fee (including revenue received by BCBS for "other services" under the ASO agreements) plus the Claims Costs

to approximate what a SF premium might be. Most recently, this argument was also articulated in the Schlegel transcript. To put it simply, BCBS and our BDO expert report are on the same page and follow the same sound logic and the same financial processes. We both recognize that comparing the FI Premium to the SF Premium Equivalent is the best and most appropriate way to evaluate and compare the revenues generated by the FI and SF plans. It is Prof. Mason who fails to follow or maybe even understand this logic.

Basing the Settlement Allocation Methodology on Operating Profit makes some sense to some degree, but it must be precise in terms of member mix and service mix to be accurate, and it depends on who you ask. According to a recent Oliver Wyman study, which Prof. Mason also references, FI represents approximately 20% of a "Typical Multi-Segment Health Plan" profit, while SF represents approximately 15%. Another 35% is split across smaller SF and FI clients. These data also underscore the inaccuracy of the proposed 95.5%/6.5% Allocation, and that our Proposed Allocation of 45.5% SF/54.5% FI is supported by this analysis.

Our value drivers in financial comparisons and subsequent Settlement Allocation methodology are summarized above in the context of responding to Prof. Mason's introductory summary comments. But they are worth re-stating here in the context of his argument in section VII: The core value drivers in the products purchased by FI and SF clients are the contracted provider network and health plan operations that support the product purchased (HMO/PPO/EPO).

In his concluding comments Prof. Mason states that Objectors ignore differences in the economics of the markets faced by the FI and SF subclasses, namely, that the Blues had more market power

in their FI product than in their SF product. Objectors did not ignore this, but rather, argue that BCBS' "market power" is omni-present and of equal value to FI and SF. This is borne out in all relevant comparative indicators, including Profit and Revenue. Importantly, as quoted at p. 4, above, Subscriber Plaintiffs admit this at page 53 of their Memorandum supporting their motion for final approval of the class settlement where they describe the antitrust damage suffered by both FI and SF plans. Moreover, Prof. Mason admits that FI and SF plans are substitutes for one another and that employers switch between them in response to changes in relative costs. (Mason Report ¶ 28.) Together these combine to clearly support the argument that the Proposed Settlement Allocation methodology is inappropriately skewed to the FI clients. The Settlement Allocation should better reflect the actual impact of BCBS anti-competitive behavior on the market, and an allocation of damages reflective of the actual value of FI and SF clients. It is clear and obvious that the Proposed Settlement Agreement Allocation substantially understates the damage allocation percentage of the SF plans.

Conclusion

In conclusion, we find four (4) significant errors in the Mason Declaration. First, not considering paid claims in the ASO revenue analysis when they are included in the FI revenue is unacceptable from an actuarial perspective and completely undermines Prof. Mason's expertise and credibility. In fact, BCBS's own executives have stated that it evaluates ASO revenues in terms of Premium Equivalency for purposes of the National Best Efforts Rule. Second, consistent misrepresentation of the ASO business as a financial drag or loss leader is not only unfactual but it is misleading. The ASO business represents a very profitable line of business that is growing and increasing in profitability, in the BCBS plans and throughout the industry. Third, application of a "Discount

Factor" to the allocation methodology is inappropriate and there is no support for it. It is absurd and an unprecedented use of a legitimate valuation tool for self-serving purposes. Fourth, we completely disagree with Prof. Mason's argument that there are market limits on Substitutability of services and he admits in his report that FI and SF are essentially substitutes for one another. As a result, our Proposed Settlement Allocation as set forth in our original Report remains unchanged.

We declare under penalty of perjury the foregoing is true and correct.

Executed this 12th day of October, 2021:

Ugo Okpewho, FSA, MAAA

Jim Watson, MBA

Exhibit 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

United States of America, et al.,	)	Civil Action No. 16-CV-1493
Plaintiffs,	)	Bench Trial
vs.	)	Washington, DC
	)	November 30, 2016
Anthem, Inc. and Cigna Corporation,	)	Morning Session
	)	Time: 9:30 A.M.
Defendants.	)	

TRANSCRIPT OF BENCH TRIAL
HELD BEFORE
THE HONORABLE JUDGE AMY BERMAN JACKSON
UNITED STATES DISTRICT JUDGE

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* * *

* * * * * * *P R O C E E D I N G S* * * * * * *

THE COURTROOM DEPUTY: Your Honor, calling Civil Action Number 16-1493, the United States of America, et al. v. Anthem and Cigna.

THE COURT: All right. You can call your next witness.

MR. CURRAN: Good morning, Your Honor.

At this time Anthem calls Mr. Stephen Schlegel, who's already on the witness stand. And my colleague Douglas Jasinski will be handling -- handling this examination.

THE COURT: All right.

STEPHEN SCHLEGEL,

was called as a witness and, having been first duly sworn, was examined and testified as follows:

MR. JASINSKI: Good morning, Your Honor.

DIRECT EXAMINATION

BY MR. JASINSKI:

Q. Could you state your name for the record, please?

A. Yes. My name is Stephen Schlegel.

Q. And what's your current role with Anthem?

A. I am the Vice President of Corporate Development.

Q. And how long have you been in that position?

A. A little over 11 years.

Q. And what was your involvement in the Cigna transaction?

A. Yeah. My involvement as Vice President of Corporate Development was to analyze the -- the transaction. It was to develop the financial analysis of it, meet with our executive leadership, our CEO and CFO, for example, meet with Cigna on occasion, work with our investment bankers and then prepare materials and analysis for our board of directors.

Q. And what type of factors did you analyze for the Cigna transaction?

A. We start with, generally, strategic fit of the two organizations, and then as a result of that strategic fit, what are the potential synergies and efficiencies of the combination, and then in -- in context of the synergies, what would be the pro forma financials of the -- of the entity and whether or not it would be of -- be attractive for our shareholders.

Q. Specific to synergies, how did you go about calculating those for the transaction?

A. Yeah. Early on, typically I will use precedent

transaction, meaning prior transactions in our space, in our -- in our industry, what was reported as synergy opportunities, what was accomplished. Also look at our own history with synergies. We've done other transactions. The Anthem, WellPoint Health networks, for example, and Amerigroup, look at those synergies that we -- we were able to capture there, and then generally look at the -- the

G & A, meaning general and administrative cost savings that we might be able to generate from the combination, and then, also, potential revenues synergies, meaning opportunities to grow our business as a result of the combination.

Q. In terms of G & A synergies, what -- what is in that bucket of synergies?

A. Yeah. What we -- what we'll do is we'll look at public information regarding the companies, the target, in this case Cigna's general and administrative expense, look at where we might be able to save between the two companies. It's typically corporate overhead, administrative expenses that we might be able to eliminate as a result of duplication.

Q. And did that include network efficiencies and medical management efficiencies?

A. Not as part of the general and administrative savings, but we did look at the opportunity to combine the best practices in medical management, wellness programs and things like that, and how it would impact our MLR. But, that was actually a relatively small amount in comparison to the G & A savings opportunity, which was probably about three-quarters of the -- of the synergies.

Q. And what part of the business did that -- the medical management efficiencies and network efficiencies relate to in the numbers that you put together for analyzing the

transaction?
A. It -- it related just to our fully insured book. So with our ASO customers, our -- were that efficiencies in savings passed directly on to our customers? We didn't necessarily size those efficiencies for the ASO customers at that -- at that point in time, but we recognize that there was going to be significant efficiencies that would flow to them post transaction, you know, both on the medical side and even on the PPM side.
Q. And then in analyzing efficiencies for the transaction, did you get input or -- or, interact with Cigna in any way for the synergies and efficiencies?
A. I did. I was asked to work with my counterpart at Cigna. What we did was we each developed independently our own viewpoints as to where the synergy opportunities would be. We developed independently our own ranges for those -- those synergies and then we came together and compared our thoughts and talked about how we got to our calculations and then compared those ranges.

Q. And what were the ranges that you came up with when analyzing the transaction?
A. The total range, in total, was 1 .7 to $2.3 billion of synergy savings.
Q. And then what -- what synergy --
THE COURT: But you're talking about exclusively

on the G & A piece?

THE WITNESS: As well as the revenue opportunity and -- and some of the network efficiencies, Your Honor.

THE COURT: So synergy savings includes -- how does synergies include increased revenue?

THE WITNESS: Well, for example, with the combined organization with our Medicaid asset, Amerigroup and their Medicare asset, HealthSpring, we saw an opportunity to better serve the dual eligible population, for example. So we believe that as a result of the combination we would be able to capture more synergies from that particular market opportunity. Another was specialty penetration. Cigna has done a very nice job of penetrating their medical membership --

THE COURT: I wasn't actually -- my question was if you're talking about synergy savings, I understand that a savings could be G & A costs going down, but you're talking about revenues going up. So I'm just wondering how you get a savings number out of costs going down and revenue going up?

THE WITNESS: Yeah. Thank you, Your Honor.

It's not necessarily a savings. It's an opportunity to improve our profitability as a result of those additional revenues.

THE COURT: Okay.

BY MR. JASINSKI:

Q. So, Mr. Schlegel, the range that you described, what was the number that -- that you provided to your executive team and board for assessing the merger?

A. Yes. We -- we settled on the mid point of that range, $2 billion. That's what we used in our analysis from that point forward in what we presented to our board of directors and ultimately to Wall Street.

Q. So -- so that 2 billion synergies number is the number that the board relied on in making an offer to Cigna?

A. It was, and obviously it's a high-level estimate at that stage.

Q. And so after the merger and agreement was signed and announced, what was the next step in calculating and estimating synergies and efficiencies between the companies?

A. As part of the integration planning effort, one of the teams that was put together was tasked with further refining both the synergy opportunity and the efficiency opportunity. I presented what I had prepared as part of the merger

analysis to that team, or to individuals on that team, which included McKinsey. And then from that point forward they took that and developed their own tops-down, bottom-up analysis to -- to get their own independent view of the synergies and the efficiencies.

Q. And that -- that would be the integration team that would include both Anthem and Cigna and McKinsey?

A. That's correct.

Q. Okay. Thank you.

I'd just like to ask you some questions about the Blue Cross and Blue Shield association. Can you just give an overview of how the association is structured?

A. Yeah. The Blue Cross/Blue Shield association itself essentially owns and controls the trademarks Blue Cross and Blue Shield and the trade names. They, in turn, license those marks and names to individual companies like ourselves. There's 36 independent companies, and it's important to note that each of them have their own management teams, board of directors, they make their own independent decisions, but as a licensee, they, in turn, govern the association through a board of directors. So each plan has a representative on the association board of directors.

Now, the association itself then conducts trade association type of activities to ensure the integrity and the value of the -- the brand and marks for the member plans.

Q. And then how does the exclusive service area under the association relate to the brands that you just described?

A. Yeah. So, the license grants the exclusive use of the brands in a defined geography, so in our case, our 14.

THE COURT: Which somewhat differentiates it from

the typical trade association.

THE WITNESS: Yes.

THE COURT: Okay.

BY MR. JASINSKI:

Q. And then so, the license gives you the right to use that brand in -- in exclusive service area?

A. That's correct. So, that means that we -- no one else can use those brands within our defined geographies and we, in turn, can't use the Blue Cross/Blue Shield brand in somebody else's licensed territory. But that exclusivity doesn't entail we have to be exclusive to the brand. We are allowed to compete with nonBlue brands both in our markets and outside of our markets.

Q. Okay. And can the exclusive service areas under the association ever overlap?

A. They do, and typically what that means is that the -- that the trademark Blue Cross and the trademark Blue Shield are separated. So perfect example of this is our Blue -- we

compete as Anthem Blue Cross in the California market against the California Blue Shield.

There's other examples of this. For example, in the state of Washington, Premier Blue Cross competes with the Regency Blue Shield. And in Idaho, the Idaho Blue Cross competes with Regency Blue Shield there. And then there's some overlapping areas within the states of Pennsylvania and

New York that I'm aware of.

Q. And are there any other instances where the Blue Cross/Blue Shield licensees compete with each other?

A. Yeah. In addition to the fact that Anthem competes in Medicare and Medicaid, for example, with our CareMore brand, Amerigroup, and then recently Simply in the state of Florida. There are other examples, such as Independence Blue Cross competes with a brand called AmeriHealth. They compete in Medicaid commercial and TPA services with that brand. So, for example, they compete as AmeriHealth New Jersey against the Blue Cross/Blue Shield of New Jersey plan.

Q. And does Anthem compete against other Blues outside of its 14 service areas?

A. We do, primarily in the Medicare and Medicaid business at this point.

Q. And that would be Amerigroup, CareMore and Simply?

A. Yes. We also do compete with a brand called HealthLink and have competed against the Blue Cross/Blue Shield plan of Illinois for the Illinois state account, for example.

Q. And HealthLink would be a commercial product?

A. It is. It's a -- it's primarily a TPA service, but it does have the insured services on that account.

Q. And then has Anthem ever competed against the Blue plans with any other nonBlue commercial brands?

A. We did. We had a brand called UniCare.
Q. And can you provide some background about the UniCare brand?
A. Yeah. UniCare was -- was a by-product of the Anthem/ WellPoint Health Networks acquisition. At one point WellPoint Health Networks was simply the -- the Blue Cross of California and they bought a couple smaller health plans from Mass Mutual and John Hancock and as part of that there was a brand called UniCare. They used that brand to compete outside of the California market. So when Anthem bought WellPoint Health Networks, that was something that we picked up. That was a line of business we picked up.
Q. And then what happened to the UniCare brand?
A. We ultimately sold the commercial membership. We still utilized the UniCare brand on some Medicare and Medicaid products. We are actually with Amerigroup, moving -- had been moving to the Amerigroup brand.

But we had sold that during the recessionary

period of 2008 and 2009. It was a business that was in decline and over time there was -- there had been some analysis, but at that point time, in 2008, we conducted a complete portfolio review. So we looked at UniCare, our PBM, NextRX. We looked at our existing state -- our Medicaid business, which is called state-sponsored business back then. And we ultimately decided to sell the UniCare

business as well as the -- the PBM.

Ultimately we did acquire Amerigroup to gain scale in the Medicaid business, but it was a part of a portfolio review.

Q. And so back to the Blue Cross and Blue Shield association, you're familiar with the best-efforts rules?

A. I am.

Q. And there are two rules, correct?

A. That's correct. And I was responsible for analyzing those rules. I identified them as a potential concern, an issue that we would have to -- to understand and -- and come to terms with.

Q. In relation to the Cigna transaction?

A. Yes.

Q. And for purposes of the Cigna transaction, which of the best-efforts rules is most relevant?

A. The most relevant one is the national Best Effort and -- and the two tests, the local Best Effort test simply says that 80 percent of our revenues, premium and premium equivalents within our defined geographies have to be Blue branded. The national test says that 66 and two-thirds or 66.6 percent of our revenues, premium and premium equivalents, have to be branded Blue.

THE COURT: What do you mean by premium and premium equivalent?

THE WITNESS: Yeah, Your Honor, premium equivalent, to -- to put an ASO account on the same basis as a fully insured account, what we do is we take the ASO fee that we collect from the client, plus the claims that we pay on their behalf, and add that together to approximate what a fully insured premium might be. That way an ASO account is on the same basis as a fully insured account.

THE COURT: Okay. All right. Thank you.

BY MR. JASINSKI:

Q. And why does the Blue Cross and Blue Shield association have a best-efforts rule?

A. It's to ensure that the licensed companies show some commitment to the brand or -- or, ensure that we are committed to the use of that brand. It's -- it's realistic to -- to -- for them, giving us an exclusive license for the use of that brand, to expect that we will use it in the markets they provide us access -- access to.

Q. And --

THE COURT: Well, then what's the point of the national one? I understand the local one.

THE WITNESS: Again, it was -- it's simply to ensure that the companies have a level of commitment to the -- to the brand.

THE COURT: Okay.

BY MR. JASINSKI:

Exhibit 2

late tonight. I think I can do the direct in 15 minutes.

THE COURT: Well, stop talking and put him on the stand.

MR. CURRAN: All right. At this time Anthem calls Mr. Wayne DeVeydt.

WAYNE DeVEYDT, Sworn

DIRECT EXAMINATION

BY MR. CURRAN:

Q. Good afternoon, Mr. DeVeydt.

A. Good afternoon.

Q. Can you please state your name.

A. Wayne DeVeydt.

Q. All right. And, sir, you are the former CFO of Anthem, correct?

A. That's correct.

Q. Thank you for being here.

Sir, you retired on or about May 31st of this year?

A. That's correct.

Q. Okay. And did your retirement have anything to do with the merger that we're litigating here today?

A. No. No. It was to spend more time with family and our philanthropic work.

Q. All right. Sir, while you were CFO at Anthem, you were one of the principal negotiators of the transaction,

correct?

A. That's correct.

Q. Sir, what was the rationale and the foreseen benefits that led Anthem to do this transaction?

A. I would break it down into three primary areas that we focused on. One was the business models were very complementary. There were areas that we were strong that Cigna was not necessarily strong in, such as individual and small group. There were areas that they were quite strong, such as what I'll call one of the vision, the dental businesses, and the penetration within their businesses. They are an international book. We had no international book. So we had a lot of unique complements to each other.

The second thing I would say is it gave us an immediate footprint to be much more competitive in all of the states outside our 14 Blue states. Now, that was very relevant because when we acquired AmeriGroup we got a very unique opportunity into what we could do with the scale and having that concentration in certain markets coupled with the value that we could bring to the transaction and become highly competitive overnight. And then finally the economics of the transaction were very compelling for both us and for the consumer.

Q. So you had high expectations for the merger?

A. Yes.

A. That's correct.
Q. And if we look at the column second to the left titled "YTD Actuals," that's year-to-date actual financial results, right?
A. That's correct.
Q. And if you look here, under -- for the ASO business, I'm not going to use the figure because it's confidential, but it's -- if you look at the screen, you can see what that number is, correct?
A. That's correct.
Q. And if you look at the figure beneath it, that's the annual operating gain for BlueCard fees. Do you see that?
A. That's correct.
Q. And the BlueCard fees are less than 10 percent or 90 percent of the ASO fees or the ASO operating gained, correct?
A. That's correct.
Q. So if you're reading this financial statement, what that means is Anthem is making almost as much operating gain on the BlueCard fees as it is on its own ASO business; is that right?
A. Well, that's a very simple way to look at it, and that would be incorrect because what you don't see from this is to just compare those two fees doesn't take into consideration all these supplemental services that are sold

to national home fully insured and national home ASO. So you have to go down and look at dental, vision, life, disability, and workers' comp because, again, if we sell a vision product to an ASO member, we put the revenue down there.

It also doesn't show you that we're able to spread our cost, our G&A cost, across a broader base which actually improves the profitability of small group/large group fully insured and large group ASO. So if you really want to -- if you're trying to do a comparison of saying, well, BlueCard is as close to as profitable to national home ASO, you have to add in all the profitability, every one of those other lines of business associated with that national home and national home ASO, to do a true comparison, and I think you'd see a substantially larger difference than what you're saying here.

Q. And, in fact, another way to compare is to look at the per member per month, right? That compares it on a per person basis; is that right?

A. Well, again, the PMPM is per member per months and typically are based on what you see here divided by membership. It doesn't consider all the other profits that are being generated from those lines of business.

THE COURT: Excuse me one second. If you took this specialties that add up, which are added up, they're

totaled, would you -- you wouldn't just add that to national. That's spread over national and large group and small group as well.

THE WITNESS: That's correct, Your Honor.

THE COURT: Okay. So only portion of that would affect the difference between national ASO and national BlueCard.

THE WITNESS: Absolutely. Absolutely.

THE COURT: Okay.

THE WITNESS: The other comment that's a little more complicated is the G&A affect. So ultimately, as an organization, you have a cost for a CEO and a CFO, and I'll give an example of two because whether you're talking about two thousand employees or two, the math works the same way. But in essence, because we're able to have the member be our member, not a BlueCard member, we actually get to spread the cost of me or the CEO or others to some of those members as well, so it actually reduces the profitability that you're seeing in national home ASO but makes the other lines of business more profitable because they're not bearing the full freight of a CFO cost.

So that's why I also mention versus BlueCard doesn't have a freight associated with it. It's just this is the fee you get, but you don't get to really see what I'll call the real profitability, the other lines of

business and all the G&A they're covering for the company.

Q. Okay. And we'll actually get to that more in the next document, but if we can just briefly go to the next page.

MR. FITZGERALD: Blow up the same box.

Q. Now, these are the same costs but now on a per-member-per-month basis, right?

A. That's correct.

Q. And if we look at the same column, second to the left, this actually shows, on a per-member-per-month basis, it's actually more profitable for Anthem to win BlueCard business than to win its own ASO business; is that right?

A. Again, I disagree. Similar to what I said when Mr. Curran was asking me questions, one of the benefits of actually winning the account directly is we get to sell ancillary services.

Per member per month on dental and on vision and on life and disability. There's a piece of that profit that actually belongs up top with national home and national home fully insured and ASO. You also have to consider the G&A leverage and disleverage.

So no, back to the point of it's a very simple view to look at that line without understanding all the other services you're selling into those members and all the other values you get on G&A leverage.

Q. Right, and you don't always sell all those services,

right?

A. Not always.

MR. FITZGERALD: Okay. If we can turn to Plaintiff's Exhibit 128, please. Turn to Page 2 before. And if we could zoom in to the bottom paragraph here.

Q. This is an email from Peter Welsh, who I believe is the regional vice president of national accounts at Anthem; is that right?

A. I don't know who Peter is.

Q. Okay. You know what Jai Bills is?

A. I know what Jai is.

Q. Jai runs the interplan business at Anthem?

A. My understanding is he does, but I don't interact directly with Jai. I haven't been with the company in six months.

Q. Okay. This is an email that was sent in 2013?

MR. FITZGERALD: And Caitlyn, if you can highlight the sentence beginning with "There may be certain cases."

Q. Now, Mr. DeVeydt, I'm not sure if you've actually seen this email before. Do you recognize it?

A. I do not.

Q. Do you want to take a moment to read it?

A. Please.

Q. I'm just going to ask you about this short email here.

A. Is it just this section you're going to inquire about?

Q. Just this short paragraph from Mr. Welsh.
A. Okay.
Q. So my understanding is here Anthem was re-evaluating its ceding policy, is that right, the balance of trade, the cedes to go in and the cedes that come out?
A. Yes. I interpret this -- I don't know who Peter is, but I interpret this as Peter saying we should do an analysis to make sure where we're making our money and where we're not and whether it's better to cede or not cede.
Q. And if it was true you were saying it's always better for Anthem to win its business itself, then it would always be better for Anthem to revoke its cedes, right?
A. But relative to this email, a guy like Peter -- I don't even know who he is, so he's further down in the organization; that for him to have the broader view that I just described to you, I would be very surprised at. And for him to understand the G&A leverage across the broader company, I would be very surprised at.

So to try to draw some conclusion from a gentleman that's pretty far down in the organization relative to understanding the bigger picture to the organization, I don't know, I'm struggling with that.
Q. I'm sure you're right, that he doesn't have the finance background you have.
THE COURT: I think everybody's made their point

on this point.

MR. FITZGERALD: Okay. I just want to focus on what he says here.

Q. He says, "There may be certain cases that we cede to X plan" -- that would be another Blue plan -- "that it makes more sense to leave as is versus attempting to secure them as home business." Do you see that?

A. I do.

Q. So here he's suggesting it's actually better to let another Blue have it than to let Anthem take the business itself. Is that right?

A. I don't read it that way.

THE COURT: He's asking if there's such information that you are considering, and let's go into the next question.

MR. FITZGERALD: Just two more documents, and then we're done. If you can pull up Plaintiff's Exhibit 37, please. If we can go to the first page, the next page.

Q. This is an email from the organization Anthem National Accounts again talking about ceding best practices. Do you see that?

A. I do.

MR. FITZGERALD: And if we can go to Page 6, please.

Q. This talks about the financial ramifications of ceding.

Do you see that?
A. I do.
Q. And on the left it talks about ASO underwriting components. This is when Anthem wins its own ASO business?
A. I've never seen this document so I don't know if that's what he means by ASO underwriting components.
Q. So as a CFO, tell me if this makes sense, it says on the left, "Anthem earns revenue on ASO fees," right?
A. That's what it says.
Q. And then it spends money on costs, which are operating expenses and taxes, and what's left is the profitability, right?
A. That's correct. That's what it says.
Q. But if you look at the right, that's the financial ramifications of BlueCard, right?
A. Actually, I think this is really a poorly done document because you still pay taxes on BlueCard fees. You still pay taxes on profitability. You actually get a G&A operating expense leverage.

So, again, I can't really speak to this document other than I can tell you as a CFO, had I gotten this, I would have told him to go back and redo it because it's just wrong.
Q. Because what the national accounts organization is saying here is the BlueCard fees go straight to the bottom

line, right?

A. Again, I don't -- there is a CFO that reported to me of national accounts, and I can assure you that CFO would have said that's not true, and I would have told you that's not true.

So, again, I think you have that wrong instead of giving some aspect of the business that they don't fully understand, back to what I said earlier, all aspects of taxation, G&A leverage, and other implications across the company.

MR. FITZGERALD: Okay. And if we can pull up Plaintiff's Exhibit 71, please.

Q. And this, again, might be another case of another Anthem executive that just doesn't know what they're talking about, but I want to read one more email.

MR. FITZGERALD: Caitlyn, if you can zoom in to the paragraph in the second email. This is from Gregory Fox.

Q. Do you know Mr. Fox?

A. I do not know Mr. Fox.

MR. FITZGERALD: Caitlyn, if you can highlight towards the end of that email where it says -- beginning with "Let's enjoy."

Q. This is an email relating to a large national account, correct?

A. Again, I've never seen this email before so.
Q. If you look at the subject line of the email, that's the name of a very large national account.
A. Okay.
Q. And that's an account that's based in Alabama, right?
A. Yes.
Q. And here Mr. Fox, the sales rep, says, "Let's enjoy the host fees from BlueCross of Alabama because that's more profit than we will ever see as the lead carrier." Do you see that?
A. I do.
Q. Okay.

MR. FITZGERALD: No further questions, Your Honor.

THE COURT: All right. Mr. Curran.

REDIRECT EXAMINATION

BY MR. CURRAN:

Q. Mr. DeVeydt, Mr. Fitzgerald asked you some questions about the UniCare experience.

A. Yes.
Q. How did that experience inform the strategy behind Anthem's proposed acquisition of Cigna?
A. The UniCare acquisition, if you go back to the mid-'90s, was a culmination of several businesses that were sold off from John Hancock and others, and it was clearly an attempt to try to compete outside of our 14 states. We're land-

locked, and one of the memos that we saw earlier, while it wasn't referenced, specifically stated we're land-locked.

And the unfortunate aspect we didn't appreciate at the time was how hard it would be to actually grow those memberships in those states without the benefit of more membership. Again, the premise being that it was a brand that nobody recognized, and more importantly, it just didn't have scale. We had some states where we had 50 customers so it's really hard to put a wellness program in place for 50 customers and spread that cost.

The probably more difficult challenge was year after year we were piling money into UniCare trying to make it work. We did a branding campaign of which very few people still know or ever heard of UniCare today. We tried to lower our prices in certain markets to get more market share. We lost money because of it, and ultimately we came to the conclusion that we just could not be successful with the asset under the mechanisms that it was determined back in the '90s. That's when it was originally started, and then we tried to make it work.

When I became CFO, we made a decision to sell the asset or, as I said, not sell but try to sell, got no buyers, so basically got a commission. But we got a lot of great lessons learned from it, and one of the lessons learned was that if you're going to get outside of our 14

states, you need a meaningful scale on Day 1 or a path to meaningful scale, and so we did the AmeriGroup transaction. We saw it as a rapid growth arena. It was a best in class management team so we thought they could really help us leverage their scale and win more contracts.

And the hypothesis proved to not only be true, but was a much bigger success than we could have imagined. In fact, right before I left they were awarded the Iowa contract in Medicaid in the state of Iowa where, again, they competed against the Blues and others.

So they have a substantial presence in Florida, the largest Medicaid, maybe -- either tied for first or close to first.

So very sizeable states that have Blues presence AmeriGroup competed in, and what it really did, if you look at the timing, is it gave us great confidence in what we could do with a Cigna transaction, and Cigna being uniquely different in AmeriGroup in that it had great brand

recognition.

So imagine being outside of our 14 states where you can't use BlueCross BlueShield but you get to use the name "Cigna," and that was really valuable to us and then, more importantly, not only to have scale, but we were starting to accumulate scale with AmeriGroup, but if you combined those two together and make investments over a

broader membership base in Florida, Texas, other arenas, where the product would be even more affordable for the consumer. So we found it to be highly compelling from that perspective.

Q. Did Anthem sign the merger agreement with the intention of letting Cigna wither away outside the 14 states and Anthem just collecting BlueCard fees?

A. Absolutely not. I mean, the intention -- and, again, I'm not CFO anymore, but I can assure you the intention was to be a very aggressive competitor in every state outside the 14 states using the Cigna brand.

MR. CURRAN: Thank you.

Thank you, Your Honor.

THE COURT: All right. You can catch your flight.

THE WITNESS: Thank you.

THE COURT: I'll see everyone else tomorrow morning at 9:30. Thank you.

(Whereupon the hearing was adjourned at 5:42 p.m.)

CERTIFICATE OF OFFICIAL COURT REPORTER

I, LISA A. MOREIRA, RDR, CRR, do hereby certify that the above and foregoing constitutes a true and accurate transcript of my stenographic notes and is a full, true and complete transcript of the proceedings to the best of my ability.

Dated this 30th day of November, 2016.

/s/Lisa A. Moreira, RDR, CRR
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